

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14143

CERTIFICATE OF DEATH

14114

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Franklin Adams		4. DATE OF DEATH Month December Day 30 Year 1959	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/28/1873
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farm owner	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Adams		14. MOTHER'S MAIDEN NAME Jane Magruder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Henry G. Morgan - Mechanicsville, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ASCVD disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 1948 to Dec 30 1959 , that I last saw the deceased alive on Dec 30 1959 , and that death occurred at 7:30 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. Roy Guyther		ADDRESS (Street, city or town, state) Mechanicsville, Md.	
DATE SIGNED 12/31/59			
PHYSICIAN'S NAME (Type) J. Roy Guyther, MD		Mechanicsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/2/60	
22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery		22d. LOCATION (City, town, or county) (State) Morganza, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		ADDRESS	
24a. REC'D BY REGISTRAR JAN 6 '60		DATE	
24b. REGISTRAR'S SIGNATURE Arthur S. Travis			

14144 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

14115
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. LENGTH OF STAY IN 1b X Rural Avenue			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cecil Middle B. Last Ayers				4. DATE OF DEATH Month December Day 19 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 11, 1902	
9. AGE (In years lost birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 57 Days 11 Hours 11 Min.		11. IF UNDER 24 HRS. Months 57 Days 11 Hours 11 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance				10b. KIND OF BUSINESS OR INDUSTRY State Road		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Noah Ayers				14. MOTHER'S MAIDEN NAME Della Channell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 232-20-4600			
17. INFORMANT Lorene Ayers				Address Avenue, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary thrombosis DUE TO (b) Hypertensive cardio vascular disease DUE TO (c) 5 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 19 54 , to Dec. , 19 59 , that I last saw the deceased alive on 19 Dec. , 19 59 , and that death occurred at 7:06 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Joseph E. Gill				ADDRESS (Street, city or town, state) Leonardtown, Md.			
PHYSICIAN'S NAME (Type) JOSEPH E. GILL, M.D.				DATE SIGNED 12/20/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-22-59		22c. NAME OF CEMETERY OR CREMATORY St Paul's		22d. LOCATION (City, town, or county) (State) Leonardtown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE McClarke Mattingly				ADDRESS Leonardtown, Md.		24a. REC'D BY REGISTRAR DEC 22 1959	
24b. REGISTRAR'S SIGNATURE Arthur S. Hays							

CERTIFICATE OF DEATH

1915

St. Mary's

Leominster

St. Mary's Hospital

Age

Death

Nov. 11, 1915

Male

West Virginia

Grave Road

Interment

Local agent

John O'Connell

225-26 State Avenue, Lowell, Mass.

Witnessed by

Physician

Signature of Physician

Physician

Physician

Physician

Physician

Physician

Physician

Physician

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14145

Item 3 Film G254 1-5-60 et

CERTIFICATE OF DEATH

Reg. Dist. No. 14116

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Park Hall				c. LENGTH OF STAY IN 1b 13yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Josephine Middle Annie Last Biscoe				4. DATE OF DEATH Month December Day 27 Year 1959			
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 1885	
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10b. KIND OF BUSINESS OR INDUSTRY Day Labor		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. none			
INFORMANT Address Julia Courtney Park Hall, Maryland							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331x DUE TO Control accident Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) Generalized arterio-sclerosis DUE TO 10 years (c)							INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Dec 25, 1959 to Dec 27, 1959 , that I last saw the deceased alive on Dec 26, 1959 , and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 12/27/59							
ACTUAL SIGNATURE P. J. Bean M. D.				DATE SIGNED 12/27/59			
PHYSICIAN'S NAME (Type) P. J. Bean M. D.				Great Mills, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-30-59		22c. NAME OF CEMETERY OR CREMATORY Zion Fair		22d. LOCATION (City, town, or county) (State) Lexington Park Md	
23. FUNERAL DIRECTOR'S SIGNATURE W.C. Mattingley Leonardtown, Maryland				ADDRESS W.C. Mattingley Leonardtown, Maryland		24a. REC'D BY REGISTRAR JAN 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

11115

STATE OF MASSACHUSETTS

BEFORE ME, the undersigned authority, on this day personally appeared _____

known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledged to me that he executed the same for the purposes and consideration therein expressed.

Given under my hand and seal of office this _____ day of _____, 19____.

Notary Public for the State of Massachusetts.

My commission expires this _____ day of _____, 19____.

Witness my hand and seal of office this _____ day of _____, 19____.

Notary Public for the State of Massachusetts.

My commission expires this _____ day of _____, 19____.

Witness my hand and seal of office this _____ day of _____, 19____.

Notary Public for the State of Massachusetts.

My commission expires this _____ day of _____, 19____.

Witness my hand and seal of office this _____ day of _____, 19____.

Notary Public for the State of Massachusetts.

My commission expires this _____ day of _____, 19____.

Witness my hand and seal of office this _____ day of _____, 19____.

Notary Public for the State of Massachusetts.

My commission expires this _____ day of _____, 19____.

Witness my hand and seal of office this _____ day of _____, 19____.

Notary Public for the State of Massachusetts.

My commission expires this _____ day of _____, 19____.

Witness my hand and seal of office this _____ day of _____, 19____.

Notary Public for the State of Massachusetts.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14117

14146

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Chaptico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Joseph Last Butler			4. DATE OF DEATH Month Dec. Day 6. Year 1959		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 18, 1936		9. AGE (in years last birthday) 23 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Clayton Butler			14. MOTHER'S MAIDEN NAME Grace Elizabeth Shorter		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes		16. SOCIAL SECURITY NO. 220-32-5676		17. INFORMANT Address James C. Butler Chaptico, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull (Intracrainial Injuries) 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH Immed.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident			
20c. TIME OF INJURY Month, Day, Year 3.45 o. m. 12.6.59 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) State highway	
20f. (City or town) Clements, St. Mary's		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE W.D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) William D. Boyd M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	
22d. LOCATION (City, town, or county) Bushwood, Md.		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.			24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
DEATH CERT.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MINISTER		17. SIGNATURE OF CLERGY		18. SIGNATURE OF OTHER	
19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER	
22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER	
34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER	
37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER	
40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER	
43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER	
49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER	
52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER	
55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER	
58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER	
64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER	
67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER	
94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER	
97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

14118

34147

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dameron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Maude Last Dunbar		4. DATE OF DEATH Month December Day 3 Year 19 59	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/21/1886
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Thomas L. Dameron		14. MOTHER'S MAIDEN NAME Amanda J. Railey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Jos. M. Dunbar - Dameron, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592X DUE TO Chrom. hepatitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chrom. hepatitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Epilepsy			INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 months
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 10 , 19 59 , to Dec. 3 , 19 59 , that I last saw the deceased alive on Dec. 3 , 19 59 , and that death occurred at 10:35 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Robert V. Fuchs Leonardtwn, Md. 12/4/59			
ACTUAL SIGNATURE Robert V. Fuchs		M.D. Leonardtwn, Md.	
PHYSICIAN'S NAME (Type) Robert Fuchs, MD		Leonardtwn, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/7/59	22c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery	22d. LOCATION (City, town, or county) (State) Ridge, Md.
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DATE DEC 14 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

DECEASED NAME LAST FIRST MIDDLE SEX AGE DATE OF BIRTH PLACE OF BIRTH OCCUPATION MARITAL STATUS COLOR RELIGION EDUCATION SERVICE GRADE PAY DATE OF DEATH PLACE OF DEATH CAUSE OF DEATH MANNER OF DEATH TIME OF DEATH TIME OF BURIAL PLACE OF BURIAL NAME OF FUNERAL HOME NAME OF MINISTER NAME OF CHURCH NAME OF CEMETERY NAME OF INTERVIEWER NAME OF REPORTER NAME OF REGISTRAR NAME OF CLERK NAME OF ASSISTANT CLERK NAME OF CHIEF CLERK NAME OF DEPUTY CLERK NAME OF SECRETARY NAME OF ASSISTANT SECRETARY NAME OF CHIEF OF BUREAU NAME OF DEPUTY CHIEF OF BUREAU NAME OF ASSISTANT CHIEF OF BUREAU NAME OF CHIEF OF DIVISION NAME OF DEPUTY CHIEF OF DIVISION NAME OF ASSISTANT CHIEF OF DIVISION NAME OF CHIEF OF SECTION NAME OF DEPUTY CHIEF OF SECTION NAME OF ASSISTANT CHIEF OF SECTION NAME OF CHIEF OF UNIT NAME OF DEPUTY CHIEF OF UNIT NAME OF ASSISTANT CHIEF OF UNIT NAME OF CHIEF OF BRANCH NAME OF DEPUTY CHIEF OF BRANCH NAME OF ASSISTANT CHIEF OF BRANCH NAME OF CHIEF OF OFFICE NAME OF DEPUTY CHIEF OF OFFICE NAME OF ASSISTANT CHIEF OF OFFICE NAME OF CHIEF OF DIVISION NAME OF DEPUTY CHIEF OF DIVISION NAME OF ASSISTANT CHIEF OF DIVISION NAME OF CHIEF OF SECTION NAME OF DEPUTY CHIEF OF SECTION NAME OF ASSISTANT CHIEF OF SECTION NAME OF CHIEF OF UNIT NAME OF DEPUTY CHIEF OF UNIT NAME OF ASSISTANT CHIEF OF UNIT NAME OF CHIEF OF BRANCH NAME OF DEPUTY CHIEF OF BRANCH NAME OF ASSISTANT CHIEF OF BRANCH NAME OF CHIEF OF OFFICE NAME OF DEPUTY CHIEF OF OFFICE NAME OF ASSISTANT CHIEF OF OFFICE	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14119

14148

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

M

078

I

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn		c. LENGTH OF STAY IN 1b Great Mills	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Marys Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Wilbur M. Godfrey		4. DATE OF DEATH December 26 19 59	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 1, 1890 ?
9. AGE (In years last birthday) 69 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator		10b. KIND OF BUSINESS OR INDUSTRY Civil Service	
11. BIRTHPLACE (State or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mr. Richard Voorhaar - Park Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation 974X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Immediate DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of prostate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Hanged self.	
20c. TIME OF INJURY Month, Day, Year 12-26-59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) St Mary Hospital		20f. (City or town) (County) (State) Leonardtwn St Mary Md	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Wm. D. Boyd, MD		DATE SIGNED 12/26/59	
EXAMINER'S NAME (Type) Wm. D. Boyd, MD		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 12/28/59	
22c. NAME OF CEMETERY OR CREMATORY J.Wm.Lee Crematory		22d. LOCATION (City, town, or county) (State) Washington, D.C.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.		24a. REC'D BY REGISTRAR DEC 30 '59	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text and includes checkboxes for various conditions.

DECEASED
Name: John Doe
Age: 45 Sex: M Race: W

DATE OF DEATH
Jan 15 1925

PLACE OF DEATH
Home

Cause of Death
1. Myocardial Infarction
2. Coronary Atherosclerosis

Attending Physician
Dr. J. A. Smith

Medical Examiner
Dr. J. A. Smith

Signature
[Signature]

14149

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Abell			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rural				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MARY Middle FLORENCE Last LAWRENCE				4. DATE OF DEATH Month December Day 11 Year 19 59			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1885	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 74 Days 74 Hours 74 Min. 74		IF UNDER 24 HRS. Months 74 Days 74 Hours 74 Min. 74
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Morris				14. MOTHER'S MAIDEN NAME Dora Owens			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Estelle L. Owens - Abell, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.0 DUE TO ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASHD DUE TO (c) ASHD						INTERVAL BETWEEN ONSET AND DEATH 5 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year 10 a.m. Dec 11, 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 25, 1959 to Dec 11, 1959 that I lost the deceased on Nov 25, 1959 , and that death occurred at 10 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Leon Berube		M.D. Mechanicsville, Md.		DATE SIGNED 12/12/59			
PHYSICIAN'S NAME (Type) Leon Berube		MD Mechanicsville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/59		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		22d. LOCATION (City, town, or county) (State) Bushwood, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR DEC 17 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MEDICAL CERTIFICATION

TO HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12142



NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF DEATH <i>Jan 15 1918</i>		PLACE OF DEATH <i>Home</i>	
MANNER OF DEATH <i>Natural</i>		CAUSE OF DEATH <i>Heart Disease</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		PERIOD OF ILLNESS <i>2 weeks</i>		PLACE OF ILLNESS <i>Home</i>		NAME OF PHYSICIAN <i>Dr. J. H. Smith</i>	
EDUCATION <i>High School</i>		OCCUPATION <i>Teacher</i>		RELIGION <i>Methodist</i>		MARRIAGE <i>Married</i>		DATE OF MARRIAGE <i>1910</i>		NAME OF SPOUSE <i>John Doe</i>	
BIRTH <i>Jan 15 1873</i>		PLACE OF BIRTH <i>Baltimore</i>		FATHER'S NAME <i>John Doe</i>		MOTHER'S NAME <i>John Doe</i>		FATHER'S OCCUPATION <i>Teacher</i>		MOTHER'S OCCUPATION <i>Teacher</i>	
DATE OF BURIAL <i>Jan 17 1918</i>		PLACE OF BURIAL <i>Home</i>		NAME OF BURIAL PLACE <i>Home</i>		NAME OF MINISTER <i>Rev. J. H. Smith</i>		NAME OF CHURCH <i>Methodist</i>		NAME OF FUNERAL HOME <i>Home</i>	



12142

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14150

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14121

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park			c. LENGTH OF STAY IN 1b Life		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First Robert Middle Leon Last Lucas			4. DATE OF DEATH Month Dec. Day 20 Year 1959		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1959	9. AGE (In years last birthday) yrs. 8	IF UNDER 1 YEAR Months 8 Days 8 Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Leroy R. Harris		14. MOTHER'S MAIDEN NAME Mae Ethel Lucas			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---		17. INFORMANT Ethel Lucas Address Lexington Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BURNS 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH IMMED.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) STOVE EXPLODED AND SET HOUSE ON FIRE			
20c. TIME OF INJURY Hour 2:54 pm Month, Day, Year 12-20 1959	20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) HOME	20f. (City or town) LEXINGTON PARK - ST MARKS MD	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE William D. Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 12/21/59	
EXAMINER'S NAME (Type) WILLIAM D. BOYD MD		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/20/59	22c. NAME OF CEMETERY OR CREMATORY St. Aloysius	22d. LOCATION (City, town, or county) Leonardtwn,	(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley			24a. REC'D BY REGISTRAR DATE DEC 28 '59		
ADDRESS Leonardtwn, Md.			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2078278XVS

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED Robert Jones		SEX Male	
AGE 45		RACE White	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan. 1, 1900	
OCCUPATION Clerk		CAUSE OF DEATH Heart Disease	
PLACE OF DEATH Home		DATE OF DEATH Jan. 15, 1945	
NAME OF PHYSICIAN Dr. J. H. Smith		NAME OF MEDICAL EXAMINER Dr. A. B. Jones	
SIGNATURE OF PHYSICIAN J. H. Smith		SIGNATURE OF MEDICAL EXAMINER A. B. Jones	
CERTIFICATE OF DEATH I hereby certify that the above named person died on the 15th day of January, 1945, at the age of 45 years, of Heart Disease.		I hereby certify that the above named person died on the 15th day of January, 1945, at the age of 45 years, of Heart Disease.	

CERTIFICATE OF DEATH

Reg. Dist. No.

14122

14151

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Martha Middle Denice Last Morgan		4. DATE OF DEATH Month Dec. Day 27 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 20, 1956
9. AGE (In years lost birthday) yrs. 3		10. IF UNDER 1 YEAR Months 1 Days 27 Hours 19 Min. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) -----		10b. KIND OF BUSINESS OR INDUSTRY -----	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Morgan		14. MOTHER'S MAIDEN NAME Hazel Watkins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT John Morgan		Address Helen, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchitis - Pneumonia 325.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Heart Failure (c) Mongolism		INTERVAL BETWEEN ONSET AND DEATH 1 week 6 mos. Since Birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1 , 19 59 , to Dec 27 , 19 59 , that I last saw the deceased alive on Dec. 27 , 19 59 , and that death occurred at 4:45 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. H. Patrick		ADDRESS (Street, city or town, state) Lexington Park Md	
PHYSICIAN'S NAME (Type) William H. Patrick M.D.		DATE SIGNED 12-28-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/59	
22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or county) (State) Leonardtown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE JAN 4 '60	
ADDRESS Leonardtown, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

CERTIFICATE OF DEATH

1911

1. Name of deceased: John J. [illegible]

2. Sex: Male

3. Age: 45

4. Date of death: Nov. 20, 1911

5. Place of death: Home, [illegible]

6. Cause of death: [illegible]

7. Signature of physician: [illegible]

8. Signature of registrar: [illegible]

9. Date of registration: [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

14. [illegible]

15. [illegible]

16. [illegible]

17. [illegible]

18. [illegible]

19. [illegible]

20. [illegible]

21. [illegible]

22. [illegible]

23. [illegible]

24. [illegible]

25. [illegible]

26. [illegible]

27. [illegible]

28. [illegible]

29. [illegible]

30. [illegible]

31. [illegible]

32. [illegible]

33. [illegible]

34. [illegible]

35. [illegible]

36. [illegible]

37. [illegible]

38. [illegible]

39. [illegible]

40. [illegible]

41. [illegible]

42. [illegible]

43. [illegible]

44. [illegible]

45. [illegible]

46. [illegible]

47. [illegible]

48. [illegible]

49. [illegible]

50. [illegible]

51. [illegible]

52. [illegible]

53. [illegible]

54. [illegible]

55. [illegible]

56. [illegible]

57. [illegible]

58. [illegible]

59. [illegible]

60. [illegible]

61. [illegible]

62. [illegible]

63. [illegible]

64. [illegible]

65. [illegible]

66. [illegible]

67. [illegible]

68. [illegible]

69. [illegible]

70. [illegible]

71. [illegible]

72. [illegible]

73. [illegible]

74. [illegible]

75. [illegible]

76. [illegible]

77. [illegible]

78. [illegible]

79. [illegible]

80. [illegible]

81. [illegible]

82. [illegible]

83. [illegible]

84. [illegible]

85. [illegible]

86. [illegible]

87. [illegible]

88. [illegible]

89. [illegible]

90. [illegible]

91. [illegible]

92. [illegible]

93. [illegible]

94. [illegible]

95. [illegible]

96. [illegible]

97. [illegible]

98. [illegible]

99. [illegible]

100. [illegible]

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14152

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14123

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Oakley		c. LENGTH OF STAY IN 1b X Rural Clements	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		/d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Benton Last Nelson		4. DATE OF DEATH Month December Day 12 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 14, 1913
9. AGE (in years last birthday) 46 yrs.		IF UNDER 1 YEAR Months 46 Days 46 Hours 46 Min. 46	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY State Road	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Francis Benton Nelson		14. MOTHER'S MAIDEN NAME Catherine Elizabeth Tennyson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII		16. SOCIAL SECURITY NO. WWII	
17. INFORMANT Catherine E. Nelson Clements, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUN SHOT 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH IMMED.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) SHOT SELF THRU MOUTH WITH SHOT GUN	
20c. TIME OF INJURY Month, Day, Year Hour 7:30 p.m. 12-12-1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ALL SAINTS CHURCH	20f. (City or town) (County) (State) YARD OAKLEY ST. MARY'S Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd M.D.		DATE SIGNED 12/14/59	
EXAMINER'S NAME (Type) William D. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/15/59	22c. NAME OF CEMETERY OR CREMATORY St. Joseph's	22d. LOCATION (City, town, or county) (State) Morganza, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Maryland		24. REC'D BY REGISTRAR DEC 16 '59	
24b. REGISTRAR'S SIGNATURE C. S. S. S.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the certificate should be executed within 72 hours after death. Page 1, 2, and 3 to the funeral director. Page 4 to the funeral director. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1

1

THIS IS TO CERTIFY THAT THE ABOVE NAMED PERSON HAS BEEN EXAMINED BY THE PHYSICIAN IN CHARGE OF THE STATE HOSPITAL AND FOUND TO BE A PATIENT OF THE HOSPITAL.

STATE OF NEW YORK
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11152

NO. 11152

DECEASED

SEX

AGE

DATE

NAME

RESIDENCE

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

SIGNATURE

PHYSICIAN IN CHARGE

DATE

PLACE

CERTIFICATE OF DEATH

DATE

PLACE

SIGNATURE

DATE

PLACE

SIGNATURE

DATE

PLACE

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DATE

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DATE

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SIGNATURE

DATE

PLACE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14124

Reg. Dist. No.

14153

1. PLACE OF DEATH a. COUNTY <u>St. Marys</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institutions Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Marys</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bushwood</u>		c. LENGTH OF STAY IN 1b 		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Coltons Point</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rural</u>				d. STREET ADDRESS <u>Rural</u>			
3. NAME OF DECEASED (Type or print) First <u>RACHAEL</u> Middle <u>ANN</u> Last <u>NELSON</u>				4. DATE OF DEATH Month <u>12</u> / Day <u>12</u> / Year <u>1959</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>8/31/1937</u>		9. AGE (In years last birthday) <u>22</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>			
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph E. Bowles</u>			
14. MOTHER'S MAIDEN NAME <u>Mary E. Brown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>			
17. INFORMANT <u>Mary E. Bowles - Coltons Point, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GUN SHOT</u> <u>981x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 M MED.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>SHOT THRU WINDOW BY HUSBAND</u>					
20c. TIME OF INJURY Hour <u>7:05</u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>OLD GUM TAVERN</u>			
20f. (City or town) <u>BUSHWOOD</u>		(County) <u>ST MARYS</u>		(State) <u>MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Wm. D. Boyd</u>		EXAMINER'S NAME (Type) <u>Wm. D. Boyd, MD.</u>		DATE SIGNED <u>12/12/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/15/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>			
22d. LOCATION (City, town, or county) <u>Bushwood, Md.</u>		22e. (State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>			
24a. REC'D BY REGISTRAR <u>DEC 17 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME
SM 2/57

VS. A15ME
SM 2/57

MEDICAL CERTIFICATION

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sandra A. Pearson		4. DATE OF DEATH Month Dec. Day 21, Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 14, 1959
9. AGE (In years last birthday) 5 wks. yrs.		IF UNDER 1 YEAR Months 1 Days 7	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY 	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Pearson		14. MOTHER'S MAIDEN NAME Alice Watson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. 	
17. INFORMANT James Pearson		Address Mechanicsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 24 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William D. Boyd M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) William D. Boyd M.D.		DATE SIGNED 12/21/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/21/59	22c. NAME OF CEMETERY OR CREMATORY St. Aloysius	22d. LOCATION (City, town, or county) (State) Leonardtown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley		24a. REC'D BY REGISTRAR DATE DEC 28 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hanks



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED

AGE AT DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF RECORDER

NAME OF ARCHIVIST

NAME OF ASSISTANT

NAME OF CLERK

NAME OF DECEASED

AGE AT DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF RECORDER

NAME OF ARCHIVIST

NAME OF ASSISTANT

NAME OF CLERK

NAME OF DECEASED

AGE AT DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

TIME OF DEATH

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF JURY

NAME OF JUDGE

NAME OF CLERK

NAME OF RECORDER

NAME OF ARCHIVIST

NAME OF ASSISTANT

NAME OF CLERK

1
FOR STATE
HEALTH DEPT.
X
I
2
2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY St. Mary's						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn			c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtwn			d. STREET ADDRESS Washington St.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington St.					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Henrietta WILMER RAGAN					4. DATE OF DEATH Month December Day 5 Year 19 59						
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 29, 1915		9. AGE (In years last birthday) 44 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Oil Co.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Lemue A. Wilmer					14. MOTHER'S MAIDEN NAME Hentietta Elizabeth Knight						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No					16. SOCIAL SECURITY NO. Mrs Welhelmina G. Howard Waldorf, Md.						
17. INFORMANT Mrs Welhelmina G. Howard Waldorf, Md.					Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Manual Strangulation 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home		20f. (City or town) (County) (State) Leonardtwn St. Mary's Md.				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Charles S. Petty					M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>						
EXAMINER'S NAME (Type) Charles S. Petty					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						
DATE SIGNED 12/6/59					Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 12/8/59		22c. NAME OF CEMETERY OR CREMATORY St. Aloysius		22d. LOCATION (City, town, or country) (State) Leonardtwn, Md.				
23. FUNERAL DIRECTOR ADDRESS W. Clarke Mattingley Leonardtown, Md.					24a. REC'D BY REGISTRAR DEC 11 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Huns				

11136

14155



St. Marks

St. Marks

St. Marks

Washington St. Washington St.

Booster 2 first team

White

Boys' Band



Boys' Band

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CERTIFICATE OF DEATH

Reg. Dist. No.

14127

14156

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland Rural		c. LENGTH OF STAY IN 1b Life		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Scotland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Benedict Middle S. Last Ridgell			4. DATE OF DEATH Month December Day 26 Year 19 59		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 31, 1884		9. AGE (In years last birthday) 75 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Austin Ridgell			14. MOTHER'S MAIDEN NAME Susan Hammett		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address Myrtle Ridgell 8716 Geren Road	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary sclerosis DUE TO (b) Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic nonspecific osteomyelitis (multiple areas)					INTERVAL BETWEEN ONSET AND DEATH 5 years 15 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from January, 1945 to Dec 26, 1959 that I last saw the deceased alive on Dec 24, 1959 , and that death occurred at 2 A M, from the causes and on the date stated above.					
ACTUAL SIGNATURE P.J. Bean		ADDRESS (Street, city or town, state) Ridge Great Mills, Md.		DATE SIGNED 12/27/59	
PHYSICIAN'S NAME (Type) P.J. Bean M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/59		22c. NAME OF CEMETERY OR CREMATORY St. Michael's	
22d. LOCATION (City, town, or county) Ridge,		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley			ADDRESS Leonardtwn, Md.		24a. REC'D BY REGISTRAR DATE MIN 4 '60
			24b. REGISTRAR'S SIGNATURE Arthur L. House		

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18155

CHARTER OF LANDS

18155

Section 1, Township 14N, Range 10E, 18155

Section 1, Township 14N, Range 10E, 18155
Section 1, Township 14N, Range 10E, 18155
Section 1, Township 14N, Range 10E, 18155

Section 1, Township 14N, Range 10E, 18155

Section 1, Township 14N, Range 10E, 18155

Section 1, Township 14N, Range 10E, 18155
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Section 1, Township 14N, Range 10E, 18155
Section 1, Township 14N, Range 10E, 18155
Section 1, Township 14N, Range 10E, 18155

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14157

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14128

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lexington Park	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) #1 Madison Avenue		d. STREET ADDRESS #1 Madison Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Steven Middle Douglas Last TERRELL		4. DATE OF DEATH Month Dec. Day 4 Year 19 59	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 Oct. 1959
9. AGE (In years last birthday) yrs. 1 Months 6 Days 6 Hours Min. 		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
13. FATHER'S NAME Billy Harten TERRELL		14. MOTHER'S MAIDEN NAME Leilani Francis HOLLAND	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. B.H. TERRELL (Father)	
17. INFORMANT #1 Madison Ave., Lexington Park, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonitis, Early, Bilateral with (c) Tracheobronchitis cause lost.		INTERVAL BETWEEN ONSET AND DEATH 4 hours.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 o. m. p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE James H. ARMSTRONG, LT JG USNR, STAHOOP, NAY, Pa. Riv., Md.		DATE SIGNED 12/8/59	
EXAMINER'S NAME (Type) Wm. D. BOYD, MD.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59	
22c. NAME OF CEMETERY OR CREMATORY Arlington National		22d. LOCATION (City, town, or county) (State) Arlington, Va.	
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley Leonardtown, Md.		24a. REC'D BY REGISTRAR DEC 11 '59	
24b. REGISTRAR'S SIGNATURE Arthur L. Howard			

2051213X05

MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
PLACE OF BIRTH [REDACTED]		OCCUPATION [REDACTED]		MARITAL STATUS [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		SIGNATURE OF MEDICAL EXAMINER [REDACTED]	
SIGNATURE OF DECEASED [REDACTED]		SIGNATURE OF NEXT OF KIN [REDACTED]		SIGNATURE OF WITNESS [REDACTED]	
SIGNATURE OF CLERK [REDACTED]		SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF JUDGE [REDACTED]	



MAINE STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

14129

14158

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY St. Mary's MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtowntown		c. LENGTH OF STAY IN 1b D.O. A		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Chaptico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Mary's Hospital			d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) James Aloysius Thomas			4. DATE OF DEATH Month Dec. Day 6, Year 19 59		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 6, 1940		9. AGE (in years last birthday) 19 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Edgar Jones			14. MOTHER'S MAIDEN NAME Mary Madeline Thomas		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mary M. Thomas Address Chaptico, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull (Intracrainial Injuries) immed. 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto. accident			
20c. TIME OF INJURY Month, Day, Year 3.45 a. m. 12. 6. 59 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Highway		20f. (City or town) (County) (State) Clements, St. Mary's	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Wm D Boyd		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) William D. Boyd M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORY Sacred Heart	
22d. LOCATION (City, town, or county) (State) Bushwood, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE W. Clarke Mattingley			24a. REC'D BY REGISTRAR DATE DEC 11 '59		
ADDRESS Leonardtowntown, Md.			24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

14159 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 14130

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clements		c. LENGTH OF STAY IN 1b X Lexington Park		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) State Highway Rt. 237			d. STREET ADDRESS 121 West Rennell		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gary Middle Alan Last Wible			4. DATE OF DEATH Month December Day 6 Year 19 59		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/16/1947		9. AGE (in years last birthday) 12 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Alan H. Wible, Jr.		
14. MOTHER'S MAIDEN NAME Florine R. Johnson			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. -----			17. INFORMANT Alan H. Wible, Jr. - Lexington Park, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured cervical vertabrae 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH immed.					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Automobile accident		
20c. TIME OF INJURY Month, Day, Year 3:45 a.m. 12/6/59		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State Hgy.	
20f. (City or town) Clements, St. Marys, Md.		20g. (County) Md.		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Wm. D. Boyd, MD			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Wm. D. Boyd, MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 12/6/59		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery	
22d. LOCATION (City, town, or county) Morganza, Md.		22e. (State) Md.		22f. (County) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.			24a. REC'D BY REGISTRAR DEC 14 '59		
24b. REGISTRAR'S SIGNATURE Arthur S. Harris			24c. (Date) DEC 14 '59		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

14160

CERTIFICATE OF DEATH

14131

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY St. Marys MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY St. Marys			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Leonardtown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Scotland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Hospital				e. STREET ADDRESS Rural		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MAUDE Middle REBECCA Last YEATMAN				4. DATE OF DEATH Month December Day 30 Year 1959			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2 / 2 / 1879	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Austin Ridgell				14. MOTHER'S MAIDEN NAME Rebecca Hammett			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mr. Lenox Yeatman - St. Inigoes, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 904.0 DUE TO Thrombophlebitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO Fracture, Left Hip (b) 5 days (c) 3 weeks							INTERVAL BETWEEN ONSET AND DEATH 4 days 5 days 3 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Scotland St. Marys Md	
21. I certify that I attended the deceased from Dec 30, 1959 , to 30 Dec 1959 , that I last saw the deceased alive on 30 Dec 1959 , and that death occurred at 2:50P M. from the causes and on the date stated above.							DATE SIGNED 12/31/59
ACTUAL SIGNATURE Ernest Rehm				M.D. Leonardtown, Md.			
PHYSICIAN'S NAME (Type) Ernest Rehm, MD				Leonardtown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/4/60		22c. NAME OF CEMETERY OR CREMATORY St. Michaels		22d. LOCATION (City, town, or county) (State) Ridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE P.B. Robinson - Leonardtown, Md.				24a. REC'D BY REGISTRAR DATE JAN 6 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

14160

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65		DATE OF BIRTH 1874	
PLACE OF BIRTH Baltimore, Md.		OCCUPATION Carpenter		CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural	
DATE OF DEATH 1940		PLACE OF DEATH Home		CERTIFICATE NO. 14160		REGISTRATION NO. 14160	
SIGNATURE OF DECEASED James H. Harris		SIGNATURE OF WITNESSES John Doe, Jane Doe		SIGNATURE OF PHYSICIAN Dr. John Smith		SIGNATURE OF REGISTRAR John Doe	
DATE OF SIGNATURE 1940		DATE OF SIGNATURE 1940		DATE OF SIGNATURE 1940		DATE OF SIGNATURE 1940	